Duty of Treatment and Duty of Care, and Scope of Insurance Coverage in Medical Liability Insurance

The subject of this publication is the duty of treatment and the duty of care, a breach of which may lead to civil liability of a physician. These duties are considered from the point of view of their scope, meaning for the responsible entity and for the insurer under civil liability insurance.

The duty of care is no less important. It applies to the entire diagnostic and therapeutic process, both to the action and omission of a physician, individual medical procedures, the use of current medical knowledge, the use of medical devices or medicinal products. The point is to exercise care and diligence required of a professional (art. 355 § 2 of the [Polish] Civil Code).

There is no doubt that a breach of the duty of treatment or the duty of care falls under the scope of insurance cover in civil liability insurance. The problem arises, however, when a certain action or omission of the doctor leads to an infringement of the patient’s right, but no personal injury occurs. Then, it has not been clearly resolved whether the mere breach of the obligation of treatment leads to the liability of the civil liability insurer. This issue is gaining more and more practical meaning.

Keywords: doctor’s liability for damage to a patient, duty of treatment, duty of care, civil liability insurance, medical insurance.

1. Introduction

In Polish law a physician, when performing professional activities, can bear both tortious liability (art. 415 of the [Polish] Civil Code) and contractual liability (art. 471 therein). The doctor’s liability indirectly depends on the nature of a legal relationship between a doctor and a patient (medical services financed from public funds and private services financed by the patient) and also whether s/he renders medical services on their own account (in an individual, specialist or a medical group practice) or on behalf and in favour of another entity (an employment contract, a civil law agreement commonly called a ‘contract’). Therefore, the source of the doctor’s civil liability may be an obligation between parties whose non-performance or malperformance raises a duty to redress damage caused to the patient – creditor as well as a wrongful act leading to detriment. If the non-performance or malperformance of the obligation by the doctor is at the same time a tort, the overlap of liability grounds occurs (art. 443 of the [Polish] Civil Code). Consequently, subject to an injured party’s choice, the doctor may be held liable ex contractu or ex delicto.

On the other hand, the Polish legislator assumes the patient’s right to medical services commonly known as the right to treatment, and at the same time also the physician’s obligation to provide medical assistance. The right to treatment is statutory, although its specific conditions may be clarified in a specific
agreement. Furthermore, two special situations are anticipated: (1) a possibility of not starting treatment at all and withdrawing from it and (2) the right to conscientious objection.

2. Duty of treatment

2.1. The patient’s right to medical services as the right to treatment

The Constitution of the Republic of Poland of 2 April 1997 provides every citizen with the right to health protection, equal access to healthcare services financed from public funds (art. 68), legal protection of life (art. 38) and protection from medical experiments performed without a patient’s permission (art. 39). As indicated in the science of law, equality discussed in art. 68 (2) of Poland’s Constitution should not be equated with the unlimited right of the patient to obtain each type of healthcare at any time. It only means the right to seek healthcare services on the basis of common rules for all potential patients. Equal access to healthcare services of appropriate quality is also provided by the European convention on bioethics (art. 3).

The rights that are listed in the Constitution of the Republic of Poland are specified in provisions of various acts. In particular, art. 6 of the Act on patient rights and patients’ ombudsman of 8 November 2008 anticipates an entitlement of the patient to ‘health services’. They should be rendered with due care and diligence in the conditions that meet professional and sanitary requirements, taking into account principles of professional ethics laid down for a given profession (art. 8 of the patient’s rights). The concept of health services is narrower than that of healthcare services, which comprise health services, benefits in kind and accompanying benefits. This conclusion is confirmed not only by an analysis of regulations, but also by judicial decisions. In its judgment of October 12, 2006, the Supreme Administrative Court in Warsaw emphasised that health services are activities of a medical character. Catering and accommodation are of different nature. Healthcare services defined precisely in the implementing regulations, financed from public funds, are granted free of charge to insured people in medical facilities that have signed appropriate agreements (commonly referred to as ‘contracts’) with the only payer (National Health Fund). However, only the entitlement to health services specified in the provisions of the Act on patient rights and patients’

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1 Health services comprise actions aimed at maintaining, rescuing, restoring and improving health as well as some other medical activities resulting from a treatment process or separate regulations on principles of their provision.
2 Health benefit in kind are drugs, medical devices related to a treatment process, including medical devices that are orthopedic items, and auxiliary agents. On the other hand, an accompanying benefit is accommodation and health-related catering in a hospital or another enterprise of a medical entity performing medical activities such as stationary and round-the-clock health services within the meaning of the regulations on medical activity, transport and sanitary transport services, as well as accommodation outside the enterprise of the medical entity if the need to provide it results from the conditions set for a given guaranteed benefit.
3 II FSK 1242/05, LEX no 280395
ombudsman is of a general nature and appertains to everybody regardless of a type of the entity that provides such services (public, private) and of the status of the patient (insured, uninsured). Therefore, the right to treatment has its source in legal provisions that define the rules for providing services as well as a catalogue of medical procedures that are free of charge for people covered by the general health insurance.

As part of the right to health services, the patient has additionally been granted two special rights:

- the right to immediate provision of health services due to a threat to life or health (art.7), however, the Act does not specify in which situations the patient’s life or health is threatened.
- the female-patient’s right to be provided health services related to childbirth (art. 7(2) of the patient’s rights). Its significant supplement is the right to request an additional doctoral or nursing (midwife’s) report or to convene a medical case conference. The entity providing health services may refuse to obtain an appropriate opinion if the request is groundless, however, both the request itself and a possible refusal to accept it should be recorded in medical documentation.

In the situation of limited possibilities of providing health services, the patient has the right to a transparent, objective, medical criteria-based procedure determining an order of access to services. In Poland, since January 1, 2015 a separate procedure qualifying patient with cancer diseases called an oncology package has been in force.

At the same time, under strictly defined circumstances, Polish law provides for coercion of treatment, which refers to the treatment of people with mental disorders, treatment of infectious diseases, treatment of people alcohol or drug-addicted and prisoners (self-injuries). In most cases, instruments of direct coercion may be applied, and certain activities may also be performed without consent, and even with the patient’s explicit objection.

### 2.2. Doctor’s duty to provide aid

Polish law does not introduce a separate obligation to treat vested in a doctor or another person performing a medical profession. However, it provides for a medical obligation to grant aid, which is regulated in art. 30 of the Medical Profession Act. Under this provision, ‘a physician is under an obligation to provide medical assistance in any case when some delay in granting it could lead to a risk of loss of life, serious injury or serious health disorder, and in some other urgent cases.’ The provision of assistance in the state of threat to life or health

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4 A slightly different solution is provided for in the medical profession act. Under art. 37 of the act, in case of any diagnostic or therapeutic doubts, the physician, on their own initiative or at the request of the patient or their legal representative, if s/he considers it justified in the light of medical knowledge requirements, s/he should consult a competent specialist doctor or arrange a medical consultation meeting.

5 More on this subject M. Serwach, ‘Oncology package and queue package - a remedy for Polish healthcare system?’ ‘Magazine: Medycyna Praktyczna 2015, no 1, p. 125 et seq.
is also treated as their vocation, which is reflected in deontological standards (art. 2 of the Medical Code of Ethics)\(^6\). This obligation applies to every physician, regardless of the form of employment, performance of professional activities or their temporary cessation, at work as well as in private life. Judicial decisions clarify that the medical obligation to provide aid is absolute and takes priority over possible restrictions resulting from contracts for the provision of healthcare services financed from public funds\(^7\). The obligation to perform health services over limit (the so-called surplus services) concerns, however, only sudden cases as a life-threatening condition. The type of health risk that requires medical intervention is irrelevant. It may be an emergency (e.g. an accident) as well as an incident related to the patient’s existing health condition. The source of danger can be a human action (a suicide attempt), animal behaviour (bite) as well as nature forces (lightning strike)\(^8\). The Supreme Court emphasises, however, that these are sudden cases that could not be predicted earlier. Article 30 of the Medical Profession Act does not apply to the services which, although being of life-saving type, are used in patients treated chronically, requiring systematic submission to various medical procedures\(^9\). The scope of activities undertaken by the physician must also depend not only on the state of current medical knowledge or applicable standards, but also on medical remedies available in the circumstances of the specific case, and on the possibilities of a proper diagnosis of a threat. It is necessary to compare the doctor’s behaviour not so much with the applicable requirements as with the standard set by such factors as: specific circumstances, time and place of the service to be provided. Only an incorrect doctor’s behaviour against defined above criteria could decide about their liability.

2.3. Withdrawal from treatment and right to conscientious objection

The patient’s right to health services is strengthened by a limited possibility of not taking or withdrawing from treatment. An entity providing health services can do so only if there is no risk of loss of life, serious injury or serious health disorder (art. 30 of the Medical Profession Act). In the absence of any contraindications of an absolute nature, when withdrawing from any treatment a doctor is obliged to warn the patient (his/her legal representative or actual guardian) about it in good time and indicate real possibilities of obtaining this service from another doctor or medical entity. In the situation where the entity performs their profession under an employment contract or as a part of the service, there must additionally be serious reasons to justify not commen-

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\(^6\) Protecting human life and health, preventing diseases, treating patients and relieving suffering is treated as a doctor’s vocation, not a duty.

\(^7\) Judgment of the Supreme Court of November 3, 2004 (III CK 546/03). Therefore, the reservations defining the quantitative limit of benefits are affected by invalidity in terms of urgent services (judgment of the Supreme Court of July 13, 2005, I CK 18/05).


\(^9\) Judgment of the Supreme Court of 4 April 2007, V CSK 396/06.
cing or withdrawing from the treatment. The important reasons can be both on the patient’s side (anticipation clauses, objection to blood supply) and on the doctor’s side (lack of appropriate qualifications, tiredness of the doctor). It is also required to obtain the prior consent of a superior. The last two requirements expressly indicate that the situation of the doctor who undertakes their activities under a contract of employment and a doctor who performs a profession in a different form (on the basis of a civil law agreement or as part of their own individual or group practice) is treated differently. The legislator also indicates not commencing or withdrawing from treatment, which means that this provision will not apply to non-therapeutic medical procedures, the performance of which the doctor may refuse in any case without additional restrictions. Furthermore, art. 38 (4) of the Medical Profession Act imposes on a doctor an obligation to record the withdrawal from the treatment and its reasons in medical documentation, but it does not stipulate such an obligation in relation to the situation of treatment being not commenced.

The conscience clause is now growing in particular importance, as evidenced by the fact that the regulations governing it were appealed against to the Constitutional Tribunal, which recognized that doctors exercising rights vested in them, are not obliged to indicate a doctor/ a medical entity in which the medical procedure may be followed.\(^\text{10}\)

The conscience clause applies to both the doctor and the nurse (midwife). In practice, it most often occurs in the situations that are not only therapeutic in nature, especially when one well-protected good is sacrificed in favour of another one (abortion, organ transplant from a living donor). Doctors may refrain from rendering medical services that are against their conscience, but they are obliged to indicate a real possibility of obtaining this service from another physician or healthcare institution and they have to justify and record this fact in medical documentation (art. 39 of the Medical Profession Act). The entity performing their profession under an employment contract should first inform their superior.

A similar solution is provided for in the Nursing Act. The nurse (midwife) has the right to refrain from performing a health service against her/his conscience (art. 23 of the Nursing Act) unless this creates a risk of loss of life or serious injury to the patient, however, s/he has to give prior notice in writing to a superior.\(^\text{11}\)

The analysis clearly shows that there is a certain hierarchy of the patient’s rights and doctor’s entitlements. The patient’s right to health services is of essence, but the doctor’s entitlement to refuse to perform a service contrary to their conscience is stronger, although it is limited by the highest good, namely health and life. A provider of health services must perform medical procedures,

\(^{10}\) Judgment of the Constitutional Tribunal of 7 October 2015, K 12/14.

\(^{11}\) Irrespectively of this, s/he also has the right to refuse to perform a medical request in exceptional cases, with immediate indication of its cause in writing (art. 22 (5) of the Nursing Act).
even if they contradict their conscience, if only the refusal could violate the interests that are highest in this hierarchy.

3. The duty of care

Irrespective of legal grounds for liability (art. 415 and art. 471 of the Civil Code), to hold the physician liable, their conduct must be culpable. The difference between liability regimes is that in the case of tortious liability, the patient must prove guilt of a tortfeasor, whereas in the regime of contractual liability blame is alleged. The physician is required to exercise due care and diligence, which is required of a professional (art. 355 § 2 of the Civil Code). S/he is also under the obligation to apply current medical knowledge, whereby both requirements are repeated in several legal regulations.

Polish law does not provide for a legal definition of fault. In the civil law doctrine, however, it is assumed that fault occurs when a perpetrator of damage can be charged with an objective and subjective impropriety of behaviour. A guilty plea can be made if the following conditions are met: unlawfulness of behaviour, perpetrator’s sanity, intentionality or alleged unintentionality.

3.1. Illegality of the doctor’s conduct

The objective element of guilt is the so-called illegitimacy understood as a contradiction between behaviour of a given entity and the whole legal order, rules of conduct defined by legal norms, principles of professional ethics, principles of social coexistence or other rules of conduct adopted in the society. So, this conduct may be unlawful, by which the doctor has not complied with a particular order or has acted against a prohibition resulting from the law, but also the conduct that does not violate any legal norm, but only the principles of deontology or the rules of caution required in relationships between people. A similar stance is taken up by the judicature, which stresses that it is not necessary to prove that the doctor is in breach of the regulations concerning the safety of life and human health to accept the responsibility of the doctor; it is enough if the fault of this person consists in neglecting the principles of caution and safety resulting from life experience and the circumstances of the accident. As the Supreme Court emphasizes, the notion of unlawfulness comprises a contradiction with the rules of social coexistence, which include carrying out surgical procedures in accordance with medical practice and with the utmost care required of medical professionals. The duty to care for human life and health may stem from the very principle of causing harm to nobody.

The provisions of the Act on profession of physicians and dentists of 5 December 1996 and the provisions of the Medical Code of Ethics impose on a physician an obligation to raise professional qualifications and, above all, to include medical technologies in force in a treatment process. In some areas of medicine there are also specific standards of diagnosis or treatment. As a consequence, the doctor’s behaviour will be unlawful also when he or she behaves in a manner inconsistent with the standards or procedures applicable in a given field of medicine.
The unlawfulness of the doctor’s behaviour may also consist in the infringement of the patient’s rights, in particular in taking up medical actions without first obtaining the patient’s informed consent or exceeding its scope. A similar view was expressed by the Court of Appeal in Warsaw in the judgment of March 31, 2006, in which it stressed that a medical procedure performed without a patient’s permission is an illegal act even if it is made in accordance with the principles of knowledge. A particular form of a doctor’s unlawful behaviour is a breach of an obligation to provide information (art. 31 of the Medical Profession Act), an obligation to maintain intimacy and dignity of a patient (art. 36 therein) and a breach of an obligation of secrecy (art. 40 therein).

The fault of the doctor as a perpetrator of damage may consist not only in a specific action, but also in omission. Unlawfulness of omission occurs when there was an obligation to act, there was a prohibition of omission or a ban on bringing down an effect, which because of the omission could have been brought down. A determined inactivity of a physician, incorrect diagnosis, non-treatment or withdrawal from treatment may be an expression of unlawful omission.

Therefore, it should be stated that the unlawfulness of the doctor’s behaviour may mean violation of the norms resulting from the applicable law, rules resulting from the principles of medical knowledge, the principles of deontology, the rules of social coexistence and provisions of a contract if it has been concluded by a doctor with a particular patient. The entire doctor’s behaviour, both activities and omissions, is assessed.

3.2. Subjective element of guilt

The civil law assumes that a person of age is compos mentis. Pursuant to art.6 of the Civil Code everyone who relies on a lack of sanity must prove this fact. The subjective element of guilt, apart from the indicated sanity, concerns the relation of the will and consciousness of an agent to his/her act. Therefore, the guilt can be attributed to the doctor when there are grounds for a negative assessment of their behaviour from the point of view of both conditions. Consequently, intentionality (direct intention or potential intention) or imputable unintentionality (recklessness, negligence) may constitute the subjective element of guilt. Intentional fault will occur when a perpetrator either intends to cause damage or agrees to it by anticipating a possibility of its occurrence. Intentional fault can have a form of recklessness, when the perpetrator is aware of the damage, but falsely believes that s/he will avoid it, and a form of negligence. In the civil law, a degree of guilt is of secondary importance in the sense that the perpetrator of the damage is responsible for every even the smallest form of guilt. Accordingly, the essence of the problem comes down to the assessment of the doctor’s breach of the duty of care.

Under art. 355 § 1 of the Civil Code the debtor is obliged to diligence generally required in relations of a given type. As specified by the judicature,
attribution of negligence to a given person is justified only if the person has behaved at a particular place and time in a manner different from the proper measure of due care and diligence. The pattern of due diligence is objective in nature. Its practical application consists in designing an appropriately concretised and socially approved model to determine a manner of conduct optimal in given conditions, and then comparing the debtor’s behaviour with such a predefined pattern. It is not only the inconsistency of their behaviour with the model, but also an opportunity conditioned by life experience and an obligation to anticipate relevant consequences of behaviour that determine whether the obliged person may be accused of lacking due diligence in completing their duties. The measure of conduct, however, cannot be formulated at the level of unenforceable obligations, detached from experience and specific circumstances.

The pattern of a good doctor depends on whether the responsible entity is a specialist in a given field of medicine or a general practitioner and a doctor without specialization. The fact whether s/he is an employee of a large facility or a small medical entity located in a small town is sometimes indicated to be significant, as well. If the medical entity does not have the right equipment or devices, the physician should perform some necessary medical activities and make a decision whether to transport the patient to another facility, if the health condition allows for it.

The pattern of proper doctor’s behaviour is also dependent on the state of medical knowledge and it changes with the progress of science and technology. A similar view was expressed in several decisions of Polish courts. According to the opinion of the Supreme Court expressed in the judgment of February 10, 2010, if the physician’s behaviour in performing a medical procedure departs from the accepted abstract standard, it speaks for their guilt. The pattern is built according to such a level of professionalism below which the conduct of a given doctor should be assessed negatively. The appropriate level of expertise is determined by qualifications (specialization, academic degree), general experience and the experience in performing specific medical procedures, a character and a scope of training in extending medical knowledge and learning new methods of treatment.

4. Breach of duty of care – special cases

The doctor’s civil liability is the so-called professional liability, in which it is essential for a physician to be a professional, professionally involved in performance of specific activities. Therefore, in the assessment of their responsibility, a decisive role is played not only by accepted standards, but also by obligations imposed on a professional who is professionally involved in providing healthcare services.

13 V CSK 287/09, not published.
The legal literature distinguishes the guilt of medical technology and the guilt not related to it. As part of the medical technique, it should be pointed out that the duty of care is breached in making a diagnosis and in a treatment process itself. In the first case, the guilt of the physician is emphasized when s/he failed to perform the necessary tests, which caused the incorrect diagnosis or delayed the proper treatment. The physician’s failure to perform additional diagnostic tests will always be a sign of improper care in determining the premises of a proper medical diagnosis. This opinion was expressed by the Supreme Court in its judgment of May 20, 2005\textsuperscript{15}. In another judgment of March 4, 2009, the Court of Appeal in Poznań added that it was a malpractice not to care for the patient properly, not to refer the patient to a specialist in due time and not to apply an appropriate postoperative supervision over the patient in a situation in which, if the doctor had exercised due diligence in this respect, damage could have been avoided\textsuperscript{16}.

In practice, the most cases of a breach of a duty of care refer to the process of providing health services. The breach of the duty of care may in fact consist in damage to a specific organ, sometimes other than that one which has been subject to medical intervention. As emphasised in the case law, the physician’s fault may be failure to exercise the utmost diligence, which is possible with currently used methods of treatment of a given disease and standard medical procedures. The patient’s permission for a surgery does not comprise a possibility of causing damage to another organ\textsuperscript{17}.

Another issue is the breach of the duty of care through application of certain abandoned treatment methods as a result of the doctor’s ignorance. The physician is supposed to demonstrate special care while choosing a treatment method, which results indirectly from the so-called competence requirement. Consequently, the physician should take only these actions for which s/he has sufficient qualifications. It obviously refers to actual and not formal rights, although the physician is obliged to constantly improve his or her skills. As rightly pointed out in the science of medical law, a specialist who does not monitor changes in the science, medical advancements and practical developments ceases to be a specialist in a given field of medicine. Similarly, some judicial decisions accepted the necessity to exclude application of old methods, which do not offer prognosis of effectiveness (or their prognosis is worse), if they are widely replaced with new methods of treatment. The doctor’s use of an abandoned treatment method that causes or enlarges damage indicates their guilt.

The competence requirement means, however, that doctors should know the limits of their skills and not undertake procedures or treatments that exceed their knowledge or professional qualifications. The obligation not to go beyond the limits of their competences is also provided by art. 10 of the Medical

\textsuperscript{15} III CK 595/04, unpublished.
\textsuperscript{16} I ACa 12/09.
\textsuperscript{17} Judgment of the Court of Appeal in Kraków of 12 Oct. 2007 r., ACa 920/07.
Code of Ethics, according to which the physician should not go beyond their professional skills while performing diagnostic, preventive, curative and certifying activities. In court decisions, it has long been pointed out that a physician who is not a specialist in a specific field should refer the patient to a doctor with appropriate qualifications, and even sensitize him or her to the need of immediate specialist treatment, especially when there is a possibility of disability. The doctor may go beyond the scope of their competence only in the event of saving someone’s life. Moreover, s/he is not responsible for the so-called science errors, i.e. errors in a diagnosis justified by the state of science or adverse effects of treatment, if the choice of a particular method was justified from the point of view of current medical knowledge.

On the other hand, the doctor’s guilt may result not only from insufficient knowledge and practical skills, corresponding to the approved model of due diligence, but also from awkwardness and carelessness of the procedure, if objectively they should not occur in specific circumstances. It is the duty of a physician to take such a course of action (treatment) that should guarantee, while maintaining the current state of knowledge and principles of diligence, a predictable effect of curing, and above all, not putting patients at risk of deteriorating their health.

However, in the group of breaches of the duty of care not resulting from a medical technique, all cases of behaviour referring to the breach of the duty of information and other professional duties imposed on the doctor are mentioned. It is emphasised that the obligation to provide information and advice to the patient is the basis for the patient’s informed consent to treatment. The breach of the duty of care also involves not informing the patient about a manner of the procedure adopted or possible to apply, about some effects of the procedure (positive, possible complications) or about a prognosis. The fault that is not related to medical technology also occurs in the case of a lack of proper supervision, in particular as part of post-operative care, undertaking a procedure in which the risk exceeds intended benefits, making blood transfusion with an inadequate group or conducting a medical experiment that poses too much risk to the patient.

In conclusion, the breach of the doctor’s duty of care may be based on carelessness in diagnostic or curative procedures, inattention in medical procedures (including surgery), as well as on actions incompatible either with the competences held or current medical knowledge and rules of the practice resulting from a lack of professional improvement. However, the physician is responsible not only for guilt in the treatment process, but also for failure to exercise due diligence in the performance of duties that do not apply to medical technology but to the patient’s rights. The breach of the duty of care may also consist in improper monitoring of the patient’s condition after providing them with a health service (in particular after an operation), and even a breach of the obligation of proper supervision, especially in relation to patients requiring special care in children’s, psychiatric and geriatric wards.
5. The scope of obligatory civil liability insurance

The doctor’s liability insurance (and in principle more broadly of an entity providing medical healthcare) may be compulsory or voluntary. Until 1 January 2012, three types of compulsory civil liability insurance existed at the same time, addressed to individual entities participating in a treatment process. Currently, the provisions of the regulation of the Minister of Finance of December 22, 2011 regarding compulsory civil liability insurance of an entity providing healthcare are applied. They define a detailed scope of insurance cover for damage resulting from provision of health services or unlawful failure to provide health services in the territory of the Republic of Poland.

As part of the above-mentioned civil liability insurance, the insurer is obliged, in principle, to remedy damage to the person. It does not matter if it is or not property damage; whether it is current or future damage if it remains in a causal relationship with an insurance accident. The remedy concerns harm which under the civil law comprises losses suffered by the injured person (damnnum emergens) and benefits (lucrum cessans), which could have been achieved if the damage had not been done to them. The scope of insurance cover also embraces damage in effect of unlawful withdrawal from treatment, non-treatment or invoking the right to conscientious objection in violation of the applicable rules. However, it has not been unequivocally determined whether or not the civil liability insurance covers cases of infringement of ‘only’ the patient’s rights in the situation where at the same time no damage has been caused to the person.

Liability insurance does not include negative effects of all events. Beyond the scope of the insurance cover in the compulsory civil liability insurance there are following types of damage: injury caused by the entity performing medical activity after having been deprived of or suspended from the right to conduct medical activity; consisting in damage, destruction or loss of things; consisting in paying contractual penalties; resulting from war, martial law, commotions and riots as well as acts of terror.

Furthermore, the binding provisions regulate in a special way the insurer’s liability for damage resulting from services in the field of plastic or aesthetic surgery as the civil liability insurance covers damage resulting from plastic surgery or cosmetic procedures only if they are granted in cases resulting from

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18 On the methods of implementation and the function of compulsory insurance, see: M. Orlicki, “Ubezpieczenia obowiązkowe”, Warsaw 2011, pp. 194-256.
19 Insurance covering damage to property requires the introduction of an individually defined clause extending liability insurance, as a consequence of the additional premium payment.
20 Negative experiences that are non-property damage, including those resulting from damage to property, are not covered by the indemnity obligation; see. M. Sajjan “Naprawienie krzywdy niemajątkowej w ramach odpowiedzialności ex contractu”, (in:) “Odpowiedzialność cywilna, księga pamiątkowa ku czci A. Szpunara”, ed. M. Pyziak-Szafnicka, Kraków 2004, p. 255
a congenital malformation, injury, disease or a consequence of its treatment. Only voluntary liability insurance or excess insurance may comprise such damage.

Irrespective of the above-mentioned exclusions from the scope of the insurance cover, the damage caused intentionally has been excluded. This conclusion is confirmed by art. 11(2) of the Act on compulsory insurance. Under this provision, the compulsory civil liability insurance contract also comprises damage caused by gross negligence of an insured person or people for whom s/he is liable. The literal interpretation of the provision justifies a conclusion that the scope of protection does not cover damage caused intentionally. A similar provision is contained in art. 827 § 1 of the Civil Code, which assumes that the insurer is free from liability, if the policyholder has caused damage intentionally. In the event of gross negligence, compensation is not due unless the agreement or the general terms and conditions of insurance provide otherwise, or the payment of compensation corresponds in the circumstances to respects of equity. Although the admissibility of extending the scope of insurance cover to damage caused intentionally is provided for in art. 827 (2) of the Civil Code, insurers and their contractors do not, in principle, benefit from such options.

However, it should be emphasised that, apart from compulsory civil liability insurance, there has also recently been a dynamic development in voluntary insurance and the so-called excess liability insurance. This is caused not only by the growing awareness of the insured that there is an increasing risk of harm in connection with performance of medical activities. These entities are also aware that the conditions of compulsory insurance are general and do not guarantee their full protection. Insurers treat doctors as a special group of entities providing health services, directing to them extensive offers of excess liability insurance and voluntary liability insurance. The first of the insurance mentioned is addressed to the doctors who are under an obligation to conclude a civil liability insurance contract, but their intention is to extend the scope of insurance cover.

6. Summing up

In conclusion, it should be stated that the physician’s primary duty is the obligation of treatment, which is not absolute, as the legislator provides for certain exceptions (withdrawal from treatment, right to conscientious objection) which, however, cannot be applied in the situation of urgent medical aid. The doctor is also obliged to exercise due diligence while performing professional activities. Damage caused by the doctor’s failure to exercise due care and diligence, in infringement of the patient’s right to treatment (including the rules of withdrawal from treatment or the clause of conscience) does not raise any

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objections. Nonetheless, it has not been resolved whether the scope of the insurance cover comprises infringement of the ‘sheer’ patient’s right (including the right to treatment) without simultaneous injury to the person.

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Obowiązek leczenia oraz obowiązek zachowania staranności a zakres ochrony ubezpieczeniowej w lekarskich ubezpieczeniach OC

Tematem niniejszej publikacji jest obowiązek leczenia oraz obowiązek zachowania staranności, których naruszenie może prowadzić do powstania odpowiedzialności cywilnej lekarza. Powołane obowiązki są rozpatrywane z punktu widzenia ich zakresu, znaczenia dla odpowiedzialnego podmiotu oraz dla ubezpieczyciela w ramach ubezpieczenia OC.
Prawo pacjenta do świadczeń zdrowotnych nazywane powszechnie prawem do leczenia odgrywa decydującą rolę w polskim systemie ochrony zdrowia. Jego podstawą są nie tylko przepisy różnych ustaw medycznych, ale przede wszystkim konstytucja RP (art. 68). Uprawnienie to może być ograniczone w sytuacji, gdy lekarz w skuteczny sposób odstąpi od prowadzonego leczenia, w ogóle nie podejmując terapii chorego lub powołując się na kla zał. Jeżeli jednak konieczne jest udzielenie określonego świadczenia zdrowotnego w ramach niezwłocznej pomocy lekarskiej, gdy zwłoka w jej udzieleniu mogłaby spowodować niebezpieczeństwo utraty życia, ciężkiego uszkodzenia ciała lub ciężkiego rozstroju zdrowia, oraz w innych przypadkach niecierpiących zwłoki – prawo pacjenta jest silniejsze niż ww. uprawnienia lekarza.
Nie mniejszą rolę odgrywa obowiązek zachowania staranności. Dotyczy on całego procesu diagnostyczno-terapeutycznego, zarówno działania, jak i zaniechania lekarza, poszczególnych procedur.
medycznych, wykorzystania aktualnej wiedzy medycznej, posługiwania się wyrobami medycznymi lub produktami leczniczymi. Chodzi przy tym o dołożenie staranności wymaganej od profesjonalisty (art. 355 § 2 k.c.).

Nie budzi wątpliwości, że naruszenie obowiązku leczenia lub obowiązku staranności objęte jest zakresem ochrony ubezpieczeniowej w ubezpieczeniach OC. Problem powstaje jednak w sytuacji, gdy określone działanie lub zaniechanie lekarza będzie prowadzić do naruszenia prawa pacjenta, ale nie dojdzie do powstania szkody na osobie. Wówczas nie zostało jednoznacznie rozstrzygnięte, czy samo naruszenie obowiązku leczenia prowadzi do powstania odpowiedzialności ubezpieczeniowej OC. Zagadnienie to nabiera coraz większego praktycznego znaczenia.

Słowa kluczowe: odpowiedzialność lekarza za szkodę wyrządzoną pacjentowi, obowiązek leczenia, obowiązek starannego działania, ubezpieczenia medyczne.